		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0035048

Facility Name: Lake Shore Healthcare & Rehab Centre

Address: 7200 N. Sheridan Road (Number) Chicago (City) 60626 (Zip Code)

County: Cook

Telephone Number: (773) 973-7200 **Fax #** (773) 973-7724

IDPA ID Number: 36-3690679

Date of Initial License for Current Owners: 28-July-92

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christopher Vicere **Telephone Number:** (773) 604-8112

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ 30-Mar-2001 (Date)
(Type or Print Name) Christopher Vicere
(Title) Chief Financial Officer

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 Report Period Beginning: 1/1/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	328	Skilled (SNF)	328	120,048	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	328	TOTALS	328	120,048	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	32,756	3,063	8,710	44,529	8
9	SNF/PED					9
10	ICF	46,255	5,963	395	52,613	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	79,011	9,026	9,105	97,142	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.92%

D. How many bed-hold days during this year were paid by Public Aid? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1-Mar-89

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 28-July-92 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 328 and days of care provided 7,312

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2000 Fiscal Year: 12/31/2000

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	344,217	119,578	38,647	502,442		502,442		502,442			1
2	Food Purchase		497,012		497,012	(35,052)	461,960	(458)	461,502			2
3	Housekeeping	305,570	105,591		411,161		411,161		411,161			3
4	Laundry	151,571	14,673		166,244		166,244		166,244			4
5	Heat and Other Utilities			275,409	275,409		275,409		275,409			5
6	Maintenance	141,578	77,865	110,412	329,855		329,855	2,883	332,738			6
7	Other (specify):*											7
8	**TOTAL General Services**	942,936	814,719	424,468	2,182,123	(35,052)	2,147,071	2,425	2,149,496			8
	B. Health Care and Programs											
9	Medical Director			19,500	19,500		19,500		19,500			9
10	Nursing and Medical Records	3,464,900	320,312	230,645	4,015,857		4,015,857		4,015,857			10
10a	Therapy			36,035	36,035		36,035		36,035			10a
11	Activities	184,482	35,837		220,319		220,319		220,319			11
12	Social Services	148,597	725		149,322		149,322		149,322			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* *Dental Services*			7,892	7,892		7,892		7,892			15
16	**TOTAL Health Care and Programs**	3,797,979	356,874	294,072	4,448,925		4,448,925		4,448,925			16
	C. General Administration											
17	Administrative	171,902		504,000	675,902		675,902	(200,550)	475,352			17
18	Directors Fees											18
19	Professional Services			36,648	36,648		36,648	9,131	45,779			19
20	Dues, Fees, Subscriptions & Promotions			73,624	73,624		73,624	(42,194)	31,430			20
21	Clerical & General Office Expenses	330,355	53,261	91,638	475,254		475,254	153,620	628,874			21
22	Employee Benefits & Payroll Taxes			781,281	781,281	35,052	816,333	10,582	826,915			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,111	7,111		7,111	2,566	9,677			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			77,472	77,472		77,472		77,472			26
27	Other (specify):*							21,764	21,764			27
28	**TOTAL General Administration**	502,257	53,261	1,571,774	2,127,292	35,052	2,162,344	(45,081)	2,117,263			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,243,172	1,224,854	2,290,314	8,758,340		8,758,340	(42,656)	8,715,684			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre #0035048 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			107,521	107,521		107,521	322,267	429,788			30
31	Amortization of Pre-Op. & Org.							10,895	10,895			31
32	Interest			11,912	11,912		11,912	820,570	832,482			32
33	Real Estate Taxes			422,240	422,240		422,240		422,240			33
34	Rent-Facility & Grounds			2,407,106	2,407,106		2,407,106	(2,400,000)	7,106			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			2,948,779	2,948,779		2,948,779	(1,246,268)	1,702,511			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		235,374	50,416	285,790		285,790		285,790			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			180,072	180,072		180,072		180,072			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		235,374	230,488	465,862		465,862		465,862			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,243,172	1,460,228	5,469,581	12,172,981		12,172,981	(1,288,924)	10,884,057			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 Report Period Beginning: 1/1/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(48,853)	30		9
10	Interest and Other Investment Income	(2,348)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(458)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(16,816)	21		24
25	Fund Raising, Advertising and Promotional	(47,097)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule **Deferred Maintenance Cost*	2,883	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (112,689)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,176,235)	various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,176,235)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,288,924)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Lake Shore Healthcare & Rehab Centre

ID# 003504B

Report Period Beginning: 1/1/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance Cost	$ 2,883	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
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70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	2,883		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 Report Period Beginning: 1/1/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(458)	0	0	0	0	0	0	0	0	0	0	(458)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	2,883	0	0	0	0	0	0	0	0	0	0	2,883	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	2,425	0	0	0	0	0	0	0	0	0	0	2,425	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(208,463)	7,913	0	0	0	0	0	0	0	0	(200,550)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	9,131	0	0	0	0	0	0	0	0	0	9,131	19
20	Fees, Subscriptions & Promotions	(47,097)	4,853	50	0	0	0	0	0	0	0	0	(42,194)	20
21	Clerical & General Office Expenses	(16,816)	168,108	2,328	0	0	0	0	0	0	0	0	153,620	21
22	Employee Benefits & Payroll Taxes	0	10,582	0	0	0	0	0	0	0	0	0	10,582	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	2,566	0	0	0	0	0	0	0	0	0	2,566	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	21,764	0	0	0	0	0	0	0	0	0	21,764	27
28	**TOTAL General Administration**	(63,913)	8,541	10,291	0	0	0	0	0	0	0	0	(45,081)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(61,488)	8,541	10,291	0	0	0	0	0	0	0	0	(42,656)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre **#** 0035048 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(48,853)	657	370,463	0	0	0	0	0	0	0	0	322,267	30
31	Amortization of Pre-Op. & Org.	0	0	10,895	0	0	0	0	0	0	0	0	10,895	31
32	Interest	(2,348)	130,579	692,339	0	0	0	0	0	0	0	0	820,570	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(2,400,000)	0	0	0	0	0	0	0	0	(2,400,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(51,201)	131,236	(1,326,303)	0	0	0	0	0	0	0	0	(1,246,268)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(112,689)	139,777	(1,316,012)	0	0	0	0	0	0	0	0	(1,288,924)	45

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		17	Salary - Cynthia and Laurence	$	Lancaster, Ltd.	100.00%	$ 271,154	$ 271,154	1
2	V		27	P/R Taxes-Cynthia & Laurence		Lancaster, Ltd.	100.00%	7,572	7,572	2
3	V		17	Management Fee Income	504,000	Lancaster, Ltd.	100.00%		(504,000)	3
4	V		19	Professional Services		Lancaster, Ltd.	100.00%	9,131	9,131	4
5	V		21	Office Expenses		Lancaster, Ltd.	100.00%	10,500	10,500	5
6	V		22	Employee Benefits		Lancaster, Ltd.	100.00%	10,582	10,582	6
7	V		24	Education & Seminars		Lancaster, Ltd.	100.00%	2,566	2,566	7
8	V		17	Administrative Consultant		Lancaster, Ltd.	100.00%	24,383	24,383	8
9	V		32	Interest	8,501	Lancaster, Ltd.	100.00%	139,080	130,579	9
10	V		30	Depreciation		Lancaster, Ltd.	100.00%	657	657	10
11	V		21	Salaries - Clerical		Lancaster, Ltd.	100.00%	157,608	157,608	11
12	V		27	P/R Taxes - Clerical		Lancaster, Ltd.	100.00%	14,192	14,192	12
13	V		20	Advertising		Lancaster, Ltd.	100.00%	4,853	4,853	13
14	Total				$ 512,501			$ 652,278	$ * 139,777	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Rental Income	$ 2,400,000	Lake Shore Associates	100.00%	$	$ (2,400,000)	15
16	V	30	Depreciation		Lake Shore Associates	100.00%	370,463	370,463	16
17	V	31	Amortization		Lake Shore Associates	100.00%	10,895	10,895	17
18	V	17	Administrative Consultant		Lake Shore Associates	100.00%	7,912	7,913	18
19	V	21	Illinois Replacement Tax		Lake Shore Associates	100.00%	2,328	2,328	19
20	V	32	Interest	94,988	Lake Shore Associates	100.00%	787,327	692,339	20
21	V	20	Licenses and Fees		Lake Shore Associates	100.00%	50	50	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 2,494,988			$ 1,178,975	$ * (1,316,012)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	Cynthia Chow	Officer	Administrative	50.00%	See Attached	30	46.15%	Lancaster	$ 166,154	17-7	1
2	Laurence Zung	Officer	Administrative	50.00%	See Attached	14	29.17%	Lancaster	105,000	17-7	2
3	Julie Chow	Asst. Administrator	Administrative	0.00%	None	40	100%	Reg. Salary	42,863	17-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 314,017		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lancaster, Ltd.
Street Address: 3520 W. Thorndale Ave.
City / State / Zip Code: Chicago, IL 60659
Phone Number: (773) 539-8181
Fax Number: (773) 539-8133

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Cynthia Chow	Hours Worked	65	7	$ 360,000	$ 360,000	30	$ 166,154	1
2	27	Cynthia Chow	Hours Worked	65	7	10,054		30	4,640	2
3	17	Laurence Zung	Hours Worked	48	7	360,000	360,000	14	105,000	3
4	27	Laurence Zung	Hours Worked	48	7	10,054		14	2,932	4
5										5
6										6
7	19	Professional Services	Management Fees	1,455,000	7	26,361		504,000	9,131	7
8	21	Office Expenses	Management Fees	1,455,000	7	30,313		504,000	10,500	8
9	22	Employee Benefits	Management Fees	1,455,000	7	30,548		504,000	10,582	9
10	24	Education & Seminars	Management Fees	1,455,000	7	7,408		504,000	2,566	10
11	17	Administrative Consultant	Management Fees	1,455,000	7	70,392		504,000	24,383	11
12	32	Interest	Management Fees	1,455,000	7	401,510		504,000	139,080	12
13	30	Depreciation	Management Fees	1,455,000	7	1,898		504,000	657	13
14	21	Salaries - Clerical	Management Fees	1,455,000	7	454,998	454,998	504,000	157,608	14
15	27	P/R Taxes Clerical	Management Fees	1,455,000	7	40,971		504,000	14,192	15
16	20	Advertising	Management Fees	1,455,000	7	14,009		504,000	4,853	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,818,516	$ 1,174,998		$ 652,278	25

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Aid Association Lutheran		X	Mortgage	$93,608.00	7/28/92	$ 9,700,000	$ 7,717,815	8/01/2012	10.00%	$ 787,327	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Lancaster, Ltd.	X		Working Capital							8,501	6
7	American National Bank		X	Working Capital	Interest only	4/30/90	1,000,000		Demand	Prime	3,411	7
8												8
9	TOTAL Facility Related				$93,608.00		$ 10,700,000	$ 7,717,815			$ 799,239	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 10,700,000	$ 7,717,815			$ 799,239	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	438,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	426,240	2
3. Under or (over) accrual (line 2 minus line 1).	$	(11,760)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	434,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	422,240	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	408,110	8
	1996	418,151	9
	1997	421,635	10
	1998	429,119	11
	1999	426,240	12

Based on 1999 Actual Taxes

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 Report Period Beginning: 1/1/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 92,769 B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 217,904
2. Number of Years Over Which it is Being Amortized: 20
3. Current Period Amortization: 10,895
4. Dates Incurred: 28-July-92

Nature of Costs: Pre-Operating Costs
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1992	$ 740,000	1
2					2
3	TOTALS			$ 740,000	3

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	328		1992		$ 11,667,460	$ 370,396	40	$ 291,687	$ (78,709)	$ 2,479,340	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1989	24,908		10			24,908	9
10	Various			1990	80,814	3,745	10	4,044	299	80,814	10
11	Various			1991	28,469	905	20	1,730	825	16,750	11
12	Various			1992	12,856	408	20	643	235	5,428	12
13	Various			1993	68,862	1,789	20	3,444	1,655	25,825	13
14	Various			1994	5,698	146	20	286	140	1,949	14
15	Various			1995	76,433	1,767	20	3,822	2,055	21,822	15
16	Fire Alarm System			1996	54,450	1,396	20	2,723	1,327	13,615	16
17	Seamco Stone Deck			1996	7,989	205	20	399	194	1,729	17
18	Roof Exhauster			1996	2,700	69	20	135	66	562	18
19	Front Sign			1996	12,020	865	20	601	(264)	2,554	19
20	Water Heating System			1997	38,800	995	20	1,940	945	7,437	20
21	Fluorescent Conversion			1997	25,353	650	20	1,268	618	4,755	21
22	Elevator Improvement			1998	55,364	1,420	20	1,420		3,728	22
23	Electronic Alzheimer Doors			1998	11,800	303	20	303		694	23
24	Elevator Interiors			1999	34,422	883	20	883		1,214	24
25	Parking Lot Resurface			1999	20,240	1,999	20	1,999		2,252	25
26	Patio Stone Decking			1999	6,465	622	20	622		865	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 12,235,103	$ 388,563		$ 317,949	$ (70,614)	$ 2,696,241	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 1,886,310	$ 64,249	$ 88,332	$ 24,083		$ 1,263,891	37
38	Current Year Purchases	48,086	9,619	9,619			9,619	38
39	Fully Depreciated Assets	179,746	16,210	13,888	(2,322)		179,746	39
40								40
41	TOTALS	$ 2,114,142	$ 90,078	$ 111,839	$ 21,761		$ 1,453,256	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 15,089,245	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 478,641	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 429,788	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (48,853)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 4,149,497	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: **N/A - Related Party Lease***

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5		***Off-site Public Storage space***			7,106			5
6								6
7	TOTAL				$ 7,106 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 15,510	$		$ 15,510	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			4,243			4,243	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			27,003			27,003	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				184,542		184,542	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39-3				2,280			2,280	12
13	**Inhalation Therapy**	39-3				1,380			1,380	13
	Other (specify): Med.Sup/Sp.Bed Rent	39-2					50,832		50,832	
14	TOTAL			$		$ 50,416	$ 235,374		$ 285,790	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (48,406)	$ (45,984)	1
2	Cash-Patient Deposits	97,577	97,577	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,417,398	2,417,398	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	84,230	84,230	6
7	Other Prepaid Expenses	14,704	14,704	7
8	Accounts Receivable (owners or related parties)	477,858	2,916,398	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,043,361	$ 5,484,323	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		740,000	13
14	Buildings, at Historical Cost		11,667,460	14
15	Leasehold Improvements, at Historical Cost	529,251	533,251	15
16	Equipment, at Historical Cost	849,380	2,117,659	16
17	Accumulated Depreciation (book methods)	(858,032)	(5,263,211)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		217,904	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(91,701)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 520,599	$ 9,921,362	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,563,960	$ 15,405,685	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 279,449	$ 279,449	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	132,494	132,494	28
29	Short-Term Notes Payable	9,771	7,427	29
30	Accrued Salaries Payable	637,239	637,239	30
31	Accrued Taxes Payable (excluding real estate taxes)	24,281	24,281	31
32	Accrued Real Estate Taxes(Sch.IX-B)	434,000	434,000	32
33	Accrued Interest Payable		64,315	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,517,234	$ 1,579,205	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,717,815	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 7,717,815	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,517,234	$ 9,297,020	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,046,726	$ 6,108,665	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,563,960	$ 15,405,685	48

***(See instructions.)**

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,067,175	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,067,175	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(20,449)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (20,449)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,046,726	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		Total After Consolidation		
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,898,208	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,898,208	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,295,563	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(1,085,106)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 210,457	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 6,108,665	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,358,566	1
2	Discounts and Allowances for all Levels	(812,020)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,546,546	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	158,141	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 158,141	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	193,384	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	22,116	19
20	Radiology and X-Ray	4,343	20
21	Other Medical Services	219,654	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 439,497	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,348	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,348	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	***Vending Commission***	6,000	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,000	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,152,532	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,182,123	31
32	Health Care	4,448,925	32
33	General Administration	2,127,292	33
	B. Capital Expense		
34	Ownership	2,948,779	34
	C. Ancillary Expense		
35	Special Cost Centers	285,790	35
36	Provider Participation Fee	180,072	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,172,981	40
41	**Income before Income Taxes (line 30 minus line 40)****	(20,449)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (20,449)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.** ***Cash Basis Tax Payer**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,992	2,205	$ 63,991	$ 29.02	1
2	Assistant Director of Nursing					2
3	Registered Nurses	62,003	67,788	1,444,946	21.32	3
4	Licensed Practical Nurses	11,532	12,809	214,812	16.77	4
5	Nurse Aides & Orderlies	163,441	175,096	1,638,937	9.36	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	16,120	17,107	184,482	10.78	10
11	Social Service Workers	13,110	14,932	148,597	9.95	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	37,392	40,057	344,217	8.59	15
16	Dishwashers					16
17	Maintenance Workers	10,759	12,491	141,578	11.33	17
18	Housekeepers	35,840	39,807	305,570	7.68	18
19	Laundry	20,866	22,464	151,571	6.75	19
20	Administrator	2,080	2,200	77,815	35.37	20
21	Assistant Administrator	3,884	4,263	94,087	22.07	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	22,034	24,002	330,355	13.76	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	7,842	8,700	102,214	11.75	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	408,895	443,921	$ 5,243,172 *	$ 11.81	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	1,189	$ 38,647	1-3	35
36	Medical Director	390	19,500	9-3	36
37	Medical Records Consultant	98	4,032	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	973	14,599	10-3	39
40	Physical Therapy Consultant	1,030	36,035	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	3,680	$ 112,813		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	5,923	$ 184,112	10-3	50
51	Licensed Practical Nurses	879	26,423	10-3	51
52	Nurse Aides	93	1,479	10-3	52
53	TOTAL (lines 50 - 52)	6,895	$ 212,014		53

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jim Farlee	Administrator	N/A	$ 77,815
Judy Lewis	Asst. Admin.	N/A	51,224
Julie Chow	Asst. Admin.	N/A	42,863
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 171,902

B. Administrative - Other

Description	Amount
Management Fees - Lancaster	$ 504,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 504,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 2,603
Richard Peelo	Accounting	2,500
David Duncan	Accounting	1,600
Winston & Strawn	Legal	7,021
Panarese & Panarese	Legal	2,363
Health Data Systems, Inc.	Data Processing	11,408
Power Software Development	Data Processing	5,031
RCN	Data Processing	1,641
Medi, Inc.	Data Processing	1,051
Personnel Planners	Payroll Tax Consultant	1,430
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 36,648

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 49,452
Unemployment Compensation Insurance	39,748
FICA Taxes	393,436
Employee Health Insurance	196,453
Employee Meals	35,052
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	9,625
Misc. Employee Benefits	36,261
Retirement Plan Contributions	16,670
Uniform Allowance	27,951
***Holiday ***	4,094
Employment Fees	7,591
Lancaster Allocation	10,582
TOTAL (agree to Schedule V, line 22, col.8)	$ 826,915

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	8,922
Health Care Worker Background Check	2,232
(Indicate # of checks performed 186)	
Licenses & Fees	6,444
Promotional Advertising	42,244
Dues & Subscriptions	13,582
Lancaster Allocation	4,853
Lake Shore Associates Allocation	50
Less: Public Relations Expense	(42,244)
Non-allowable advertising	(4,853)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 31,430

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,296
Seminar Expense	4,815
Lancaster Allocation	2,566
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,677

**See instructions.

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Painting and Decorating	1996	$ 19,159	3	$ 6,386	$ 6,386	$ 3,194	$	$	$	$	$	$
2	Painting and Decorating	Mar-97	2,805	3	467	935	935	468					
3	Painting and Decorating	Apr-97	5,116	3	853	1,705	1,705	853					
4	Painting and Decorating	Aug-97	3,270	3	545	1,090	1,090	545					
5	Painting and Decorating	Mar-98	3,052	3		509	1,017	1,017	509				
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 33,402		$ 8,251	$ 10,625	$ 7,941	$ 2,883	$ 509	$	$	$	$

Facility Name & ID Number Lake Shore Healthcare & Rehab Centre # 0035048 Report Period Beginning: 1/1/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council on Long Term Care $12,858**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,620** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **180,072**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **35,052** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.